Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: INTEGRA SPECIALTY GROUP, P.A. 517 N. CARRIER PARKWAY, SUITE G GRAND PRAIRIE, TX 75050	MFDR Tracking #: M4-10-3671-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Carrier's Austin Representative Box #: POLY AMERICA INC Box #: 11	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position statement in accordance with rule §133.307. The following is taken from the DWC-60 table of disputed services: "Medically Necessary, Compensable Injury/CCH attached, No EOB/Pre-Authorization #1042038 F O"

Amount in Dispute: $4,898.76

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor (HCP) in this dispute is seeking reimbursement for services rendered on 22 dates of service between 6/24/09 and 1/15/10 and the rationale for seeking additional reimbursement is that they billed for the compensable injury as stated in the CCH decision on 9/9/08. What the requestor fails to mention is that the CCH decision rendered on 9/9/08 also ruled that the compensable injury did NOT include Spondylolisthesis at L5-S1 and Foraminal Stenosis at L5-S1. While the compensable injury includes findings of disc bulge at L4-5 and disc bulge with annular tear at L5-S1, the medical documentation clearly shows that the claimant's "condition" is a result of spondylolisthesis at L5-S1 and foraminal stenosis at L5-S1. Beginning with the initial MRI performed on 10/17/2006, the impression was:

1. Mild hyperlordosis;
2. Mild/Moderate spondylitic disc disease at L3-4. No stenosis or neural impingement;
3. L5-S1 moderate spondylitic disc disease;
4. L5-S1 Grade I degenerative spondylolisthesis resulting in foraminal stenosis and exiting L5 nerve root impingement.

The Designated Doctor found the claimant to be at MMI on 3/12/07. His report states that Dr. Van Hall {sic} records indicating 5 segments with an L pars elongation or possible pars defect and grade I-II listhesis. Peer Review dated 10/16/07 states that complaints are related to pre-existing disc and joint disease of the lumbar spine, grade I spondylolisthesis. Medical report from Dr. Gary Ogin dated 2/25/08 indicates possible pars fracture continuing the need for surgical repair if the fracture exists. RISK MANAGEMENT, WITHOUT THE RISK. CT scan dated 3/5/08 – impression is:

1. Bilateral pars spondylosis at L5 with 5.4 mm of spondylolisthesis of L5 on S1;
2. Generalized disc bulging spans the L5-S1 disc space. It extends into each neural foramen;
3. Bilateral foraminal stenosis at L5-S1 with potential compression of both L5 nerve roots in the neural foramina;
4. The L3-4 and L4-5 disc spaces are unremarkable.

Finally, the operative report of 8/26/09 clearly states the preoperative and postoperative diagnosis as :

1. Spondylosis, L5-S1;
2. Spondylolisthesis, L5-S1;
3. Foraminal Stenosis, L5-S1 with bilateral lower extremity radiculopathy.

This medical documentation should have been more than sufficient for the Requestor to realize that the claimant's condition is a result of Spondylolisthesis and Foraminal Stenosis at L5-S1 which was found NOT to be compensable per the CCH decision on 9/9/08. However, the requestor feels that by simply billing the Carrier and coding their bills to reflect the compensable diagnosis, they should receive reimbursement which should not be the case. In addition, the requestor has failed to submit any medical documentation to support their stance that the claimant's condition they are treating is related to the findings of L3-4 disc bulge and disc bulge with annular tear at L5-S1. Requestor has stated they did not

receive EOB's for DOS 12/15/09, 12/17/09, 1/6/10 and 1/8/10, please find attached EOB's that the carrier sent to the Requestor. The Respondent/Carrier contends that the submitted bills were processed correctly and were denied in accordance with the decision rendered on 9/9/08 by the TDIDWC hearing officer. The Respondent/Carrier should not be responsible for any additional payment on the bills in question."

Response Submitted by: Noemi Lugo, Avizent Frank Gates Service Co/Attenta, PO Box 803355, Dallas, TX 75380

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
6/24/09	99080-73	Rule §129.5	$15.00	$15.00
7/20/09	99080-73	Rule §129.5	$15.00	$15.00
7/20/09	99213	53.68 ÷ 36.0666 x $61.76 = $91.92	$91.92	$91.92
8/11/09	99213	53.68 ÷ 36.0666 x $61.76 = $91.92	$91.92	$91.92
8//25/09	99080-73	Rule §129.5	$15.00	$15.00
8/25/09	99213	53.68 ÷ 36.0666 x $61.76 = $91.92	$91.92	$91.92
10/8/09	99080-73	Rule §129.5	$15.00	$15.00
10/8/09	99212	53.68 ÷36.0666 x $37.43 = $55.71	$55.71	$55.71
10/13/09	99213	53.68 ÷ 36.0666 x $61.76 = $91.92	$91.92	$91.92
11/11/09	99080-73	Rule §129.5	$15.00	$15.00
11/11/09	99213	53.68 ÷ 36.0666 x $61.76 = $91.92	$91.92	$91.92
12/1/09	99213	53.68 ÷ 36.0666 x $61.76 = $91.92	$91.92	$91.92
12/2/09	95851	N/A	$24.30	$0.00
12/15/09	97110	53.68 ÷36.0666 x $28.37 = $42.22 x 2 units = $84.45	$168.88	$84.45
12/15/09	97112	53.68 ÷ 36.0666 x $29.05 = $43.24	$43.24	$43.24
12/15/09	97140	53.68 ÷ 36.0666 x $26.16 = $38.94	$38.94	$38.94
12/15/09	99080-73	Rule §129.5	$15.00	$15.00
12/15/09	99213	53.68 ÷ 36.0666 x $61.76 = $91.92	$91.92	$91.92
12/16/09	97110	53.68 ÷36.0666 x $28.37 = $42.22 x 2 units = $84.45	$168.88	$84.45
12/16/09	97112	53.68 ÷ 36.0666 x $29.05 = $43.24	$43.24	$43.24
12/16/09	97140	53.68 ÷ 36.0666 x $26.16 = $38.94	$38.94	$38.94
12/16/09	99213	53.68 ÷ 36.0666 x $61.76 = $91.92	$91.92	$91.92
12/17/09	97110	53.68 ÷36.0666 x $28.37 = $42.22 x 2 units = $84.45	$168.88	$84.45
12/17/09	97112	53.68 ÷ 36.0666 x $29.05 = $43.24	$43.24	$43.24
12/17/09	97140	53.68 ÷ 36.0666 x $26.16 = $38.94	$38.94	$38.94
12/17/09	99213	53.68 ÷ 36.0666 x $61.76 = $91.92	$91.92	$91.92
12/21/09	97110	53.68 ÷36.0666 x $28.37 = $42.22 x 2 units = $84.45	$168.88	$84.45
12/21/09	97112	53.68 ÷ 36.0666 x $29.05 = $43.24	$43.24	$43.24
12/21/09	97140	53.68 ÷ 36.0666 x $26.16 = $38.94	$38.94	$38.94
12/21/09	99213	53.68 ÷ 36.0666 x $61.76 = $91.92	$91.92	$91.92
12/23/09	97110	53.68 ÷36.0666 x $28.37 = $42.22 x 2 units = $84.45	$168.88	$84.45
12/23/09	97112	53.68 ÷ 36.0666 x $29.05 = $43.24	$43.24	$43.24
12/23/09	97140	53.68 ÷ 36.0666 x $26.16 = $38.94	$38.94	$38.94
12/23/09	99213	53.68 ÷ 36.0666 x $61.76 = $91.92	$91.92	$91.92
12/28/09	97110	53.68 ÷36.0666 x $28.37 = $42.22 x 2 units = $84.45	$168.88	$84.45
12/28/09	97112	53.68 ÷ 36.0666 x $29.05 = $43.24	$43.24	$43.24
12/28/09	97140	53.68 ÷ 36.0666 x $26.16 = $38.94	$38.94	$38.94
12/28/09	99213	53.68 ÷ 36.0666 x $61.76 = $91.92	$91.92	$91.92
12/30/09	97110	53.68 ÷36.0666 x $28.37 = $42.22 x 2 units = $84.45	$168.88	$84.45
12/30/09	97112	53.68 ÷ 36.0666 x $29.05 = $43.24	$43.24	$43.24
12/30/09	97140	53.68 ÷ 36.0666 x $26.16 = $38.94	$38.94	$38.94
12/30/09	99213	53.68 ÷ 36.0666 x $61.76 = $91.92	$91.92	$91.92

1/4/10	97110	54.32 ÷ 36.0791 x $28.70 = $43.21 x 2 units = $86.42	$172.80	$86.42
1/4/10	97112	54.32 ÷ 36.0791 x $29.78 = $44.84	$45.45	$44.84
1/4/10	99213	54.32 ÷ 36.0791 X $65.85 = $99.14	$99.68	$99.14
1/6/10	97110	54.32 ÷ 36.0791 x $28.70 = $43.21 x 2 units = $86.42	$172.80	$86.42
1/6/10	97112	54.32 ÷ 36.0791 x $29.78 = $44.84	$45.45	$44.84
1/6/10	97140	54.32 ÷ 36.0791 x $26.89 = $40.49	$40.48	$40.49
1/6/10	99213	54.32 ÷ 36.0791 X $65.85 = $99.14	$99.68	$99.14
1/8/10	97110	54.32 ÷ 36.0791 x $28.70 = $43.21 x 2 units = $86.42	$172.80	$86.42
1/8/10	97112	54.32 ÷ 36.0791 x $29.78 = $44.84	$45.45	$44.84
1/8/10	97140	54.32 ÷ 36.0791 x $26.89 = $40.49	$40.48	$40.49
1/8/10	99080-73	Rule §129.5	$15.00	$15.00
1/8/10	99213	54.32 ÷ 36.0791 X $65.85 = $99.14	$99.68	$99.14
1/12/10	97110	54.32 ÷ 36.0791 x $28.70 = $43.21 x 2 units = $86.42	$172.80	$86.42
1/12/10	97112	54.32 ÷ 36.0791 x $29.78 = $44.84	$45.45	$44.84
1/12/10	97140	54.32 ÷ 36.0791 x $26.89 = $40.49	$40.48	$40.49
1/12/10	99213	54.32 ÷ 36.0791 X $65.85 = $99.14	$99.68	$99.14
1/13/10	97110	54.32 ÷ 36.0791 x $28.70 = $43.21 x 2 units = $86.42	$129.60	$86.42
1/13/10	97112	54.32 ÷ 36.0791 x $29.78 = $44.84	$45.45	$44.84
1/13/10	97140	54.32 ÷ 36.0791 x $26.89 = $40.49	$40.48	$40.49
1/13/10	99213	54.32 ÷ 36.0791 X $65.85 = $99.14	$99.68	$99.14
1/15/10	95833	N/A	$53.00	$0.00
			Total Due:	$3,836.04

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of health care .
3. 28 Tex. Admin. Code §134.203 sets out the medical fee guidelines for professional services rendered on or after March 1, 2008.
4. 28 Tex. Admin. Code §129.5 sets out the guidelines for work status reports.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated 7/15/2009 thru 2/8/2010 for dates of service 6/24/2009, 7/20/2009, 8/11/2009, 10/8/2009, 10/13/2009, 11/11/2009, 12/1/2009, 12/2/2009, 12/16/2009,12/21/2009,12/23/2009, 12/28/2009, 12/30/2009, 1/4/2010, 1/8/2010, 1/12/2010, 1/13/2010, and 1/15/2010

- 217 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
- 219 – Based on extent of injury
- 216 – Based on the findings of a review organization

Explanation of benefits dated 3/15/2010 for dates of service 6/24/2009, 7/20/2009, 8/11/2009, 8/25/2009, 10/8/2009, 10/13/2009, 11/11/2009, 12/1/2009, 12/2/2009, 12/16/2009, 12/21/2009, 12/23/2009, 12/28/2009,12/30/2009, 1/4/2010, 1/8/2010, 1/12/2010, 1/13/2010 and 1/15/2010

- 193 – Original payment decision is being maintained. This claim was processed properly the first time.

Explanation of benefits submitted by the respondent dated 2/25/2010 and 3/23/2010 for dates of service 12/17/2009, 1/6/2010, and 1/8/2010

- 219 – Based on extent of injury

Issues

1. Has the extent of injury issue been resolved?
2. Did the requestor treat the compensable injury and did the requestor request preauthorization for the compensable injury?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed for work status reports, CPT code 99080-73 on 6/24/09, 7/20/09, 8/25/09, 10/8/2009, 11/11/2009, 12/15/2009 and 1/8/2009. The insurance carrier denied payment for these reports per above reason codes "217" and "219". Pursuant to rule §129.5(i) Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. Therefore, the insurance carrier's reason code of "217 – based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement " is not supported. The requestor and the respondent submitted a copy of a Contested Case Hearing (CCH) Decision and Order (DO) signed September 4th, 2008. The DO states "The compensable injury of August 26, 2006 includes disc bulge at L3-4 and disc bulge with annular tear at L5-S1 by operation of extent waiver; the compensable injury does not include spondylolisthesis at L5-S1 or foraminal stenosis at L5-S1". Each of the work status reports were included by the requestor in this dispute and are reviewed. The reports support diagnosis code 724.2 (lumbago/low back pain) and 722.10 (lumbar intervertebral disc without myelopathy). The requestor's submitted documentation supports the provider did treat the compensable injury and therefore, the insurance carrier's denial of "219 – Based on extent of injury" is not supported.
2. The requestor billed evaluation and management office visit CPT codes 99212 and 99213 on the above dates of service and the insurance carrier denied these office visits with reason code "219". Review of the requestor's submitted documentation for each of these dates of service support that the diagnosis for each of these visits is 722.10 (lumbar intervertebral disc without myelopathy) and 724.2 (lumbago/low back pain). Per the CCH Decision and Order stated above, the insurance carrier's denial reason of "219" for the office visits rendered is not supported. The requestor billed CPT code 95851 (Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each truck section (spine) on 12/2/09 and CPT code 95833(muscle testing, manual (separate procedure) with report; total evaluation of body, excluding hands) on 1/15/10 . Review of the requestor's documentation for 12/2/09 and 1/15/10 states "completed Range of Motion testing on one area this day (see report)". There are no reports submitted to support these charges. Pursuant to rule §134.203 (a)(5) "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and **reporting** payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare. Therefore, reimbursement to the requestor for CPT code 95851 for date of service 12/2/09 and CPT code 95833 for date of service 1/15/10 is not recommended. The requestor also billed disputed physical therapy CPT codes 97110 (4 units), 97112 (1 unit), and 97140 (1 unit); total of 6 units, for 12 visits on the above listed dates of service. The insurance carrier denied these services with reason code "219". As stated above, the diagnosis codes supported on the documentation and supported on the billing are 724.2 and 722.10. The documentation that the requestor submitted for each date of service supports the provider treated the compensable injury. Furthermore, the requestor submitted a copy of a preauthorization **approval** from the insurance carrier for the physical therapy services which supports "Date Request Received: December 8, 2009; **Diagnosis: 724.2 Lumbago**… recommend AUTHORIZATION of outpatient post operative physical therapy (PT) three (3) times a week for four (4) weeks as related to the lumbar…not to exceed more than 4 units per session". The requestor is disputing 6 billed units for each date of service. Only 4 units are payable. Therefore, the insurance carrier's denial of "219" for the physical therapy services rendered on the above listed dates of service is not supported. Reimbursement to the requestor for the above listed work status reports, office visits and physical therapy services (4 total units each visit), is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $3,836.04.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $3,836.04 plus applicable accrued interest per Division rule at 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	**6/29/11** Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.